PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D75

PROVIDER -
Logos Healthcare Rehabilitation of
South Carolina, Inc.
West Columbia, SC

Provider No.: 42-6548

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
June 10, 2005

Cost Reporting Period Ended -
December 31, 1995

CASE NO.: 00-3353

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MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

[1] The Provider and Intermediary issue numbers are the same in this case except for issues 20 and 21. For simplicity, this decision uses the Intermediary's issue numbers except for issue 21 and notes the different Provider issue numbers in parenthesis. In its initial position paper, the Provider indicated that issues 21 and 22 were withdrawn. The Provider subsequently added an issue 21 by letter dated October 9, 2001. The Intermediary did not address issue 21 in its position paper.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Logos Healthcare Rehabilitation of South Carolina, Incorporated (the Provider) is a privately owned, for-profit, outpatient rehabilitation facility located in West Columbia, South Carolina. The Provider was one of three Medicare-certified facilities in the PTK Management, Incorporated (PTK) chain of healthcare facilities. The Provider furnished outpatient physical, speech, and occupational therapy to Medicare patients in various nursing homes. The Provider claimed costs for its facility's services on its fiscal year ended December 31, 1995 cost report and also included home office costs allocated from PTK.

The Provider terminated from the Medicare program on April 30, 1999. The Provider's fiscal intermediary at the time of its termination was Blue Cross Blue Shield of North Carolina.[2] The Intermediary entered into an inter-plan agreement with First Coast Service Options, Incorporated (First Coast) to perform the outstanding audits on all Logos facilities. First Coast made the audit adjustments at issue in this case in a Notice of Program Reimbursement (NPR) issued on June 27, 2000. The Provider timely appealed the adjustments to the Provider Reimbursement Review Board (Board) and met the jurisdictional requirements of 42 C.F.R. §§405.1831-405.1841.

The Board held a hearing for this case on November 7, 2001. Because of concerns raised at the hearing, the Board suspended the hearing and agreed to hear this case on the written record. See, Tr. at 11. Because so many of the Intermediary's adjustments were due to lack of documentation and the Provider contended that a full review of its documentation had not occurred, the Board asked that additional audit work be performed and allowed the Provider to submit additional documentation. At the Board's request, the Intermediary reviewed the additional documentation and on January 30, 2003, submitted a report and made post-audit adjustments. See, Exhibit I-4.

In order to facilitate consideration of the case on the record, the Board asked the Intermediary to submit a supplemental position paper that addresses any costs disallowed after the reaudit and state; 1) why the initial audit adjustment was made; 2) what additional documentation the Provider submitted; and 3) why that documentation was not

[2] Currently, Cahaba Safeguard Administrators, LLC is the Program Safeguard Contractor and Palmetto Government Benefits Administrator is the Intermediary. All three entities will be referred to as the Intermediary.

sufficient to reverse the adjustment.[3] After receipt of the Intermediary's supplemental position paper, the Provider was permitted to submit a brief in response to the Intermediary's revised positions and to submit to the Board documentation necessary to support its position. The Intermediary submitted its supplemental position paper on March 30, 2005. The Provider did not submit anything further. The record hearing was held on June 10, 2005.

When submitting documentation to support costs disallowed due to lack of documentation, the Provider also submitted a revised working trial. The Intermediary incorporated the entire working trial balance into the cost report resulting in revisions to Schedule A for total expenses,[4] Schedule A-3 for adjustments to costs and Schedule C for revenues.

The Provider was represented by Thomas William Baker, Esquire, of Troutman Sanders LLP. The Intermediary was represented by Eileen Bradley, Esquire, and Bernard Talbert, Esquire, of the Blue Cross Blue Shield Association.

Issue 1. Did the Intermediary improperly reopen the cost report?

FACTS:

The Provider filed its Medicare cost report for FYE December 31, 1995 on May 31, 1996. The Intermediary issued its NPR for fiscal year 1995 on June 27, 2000.

PARTIES' CONTENTIONS:

The Provider asserts that because the Intermediary failed to issue an NPR within 12 months of the Provider's filing, the NPR is untimely under 42 C.F.R. §405.1835(c). According to the Provider it follows that failure to issue a timely NPR results in the Provider's cost report becoming the final determination for purposes of future appeals as of the date it was filed. CMS Pub. 15-1 §2905. The Provider contends that since the cost report became final upon the filing date, the Intermediary's June 27, 2000 NPR is a reopening beyond the three-year limit provided by 42 C.F.R. §405.1885.

The Intermediary responds that the Provider's cost report for fiscal year ended December 31, 1995 was not reopened, nor was a notice of reopening sent to the Provider. The NPR issued on June 27, 2000 is the Intermediary's final determination pursuant to 42 C.F.R. §405.1803 and is not a revision or reopening of an earlier determination under 42 C.F.R. §405.1885. The Intermediary disputes the Provider's contention that the failure to issue an NPR within the 12-month period following the filing of the as-filed cost report results in the as-filed cost report becoming the final determination.

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[3] See, Board letter dated January 28, 2005

[4] With the incorporation of the Provider's revised trial balance, the Intermediary proposed an adjustment to include management fees of $315,593 paid to a related organization on Worksheet A-3-1. The reconciliation of the costs claimed on a Medicare cost report to a provider's books is an integral part of an audit and is consistent with audit guidelines.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The Medicare regulations do not provide that a filed cost report automatically becomes a final intermediary determination if the intermediary does not issue an NPR within the 12-month period after it is filed. The regulations provide that the intermediary must issue its final determination within a reasonable time frame, and if the intermediary has not issued an NPR within a 12-month period, a provider is entitled to a hearing before the Board. 42 C.F.R. §§405.1803(a) and 405.1835(c). If the Provider's position were correct, there would be no need for a provision allowing a provider to appeal when the intermediary has not issued an NPR within 12 months. The Board finds that the Provider's December 31, 1995 as-filed cost report did not become an Intermediary final determination and that the Intermediary's June 27, 2000 NPR was the Intermediary's final determination. Therefore, the Provider's argument that the cost report was reopened after the 3-year limitation is without merit.

Issues 2-4. Were the Intermediary's adjustments to salaries – physical, speech and occupational therapy proper?

FACTS:

The Intermediary disallowed the Provider's claimed salaries – physical, speech and occupational therapy - for lack of documentation. Additional material subsequently supplied by the Provider did not contain any documentation regarding these salaries. See Intermediary's Supplemental Position Paper at 13-14.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation available at the facility and, therefore, has no basis to disallow these costs.

The Intermediary states that the Provider did not submit any additional documentation but did submit a revised trial balance that did not contain salaries for physical, speech or occupational therapy. The Intermediary reversed its initial adjustment removing these items, thereby zeroing out the negative adjustment. See, Intermediary's Supplemental Position Paper at 13-14 and Exhibit I-6 at pages 6, 7 and 8.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the reversal of its adjustment was not included in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed reversal of its adjustments are proper.

Issue 5. Was the Intermediary's adjustment to salaries – administrative proper?

FACTS:

The Provider claimed salaries – administrative which the Intermediary disallow due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed some additional salaries - administrative. See, Intermediary's Supplemental Position Paper at 15.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation available at the facility and, therefore, has no basis to disallow these costs.

The Intermediary states that the Provider submitted additional documentation in the form of W-2 forms for individual employees, but several copies of the W-2s submitted by the Provider were not eligible and, therefore, the associated salaries are not allowable. However, the Intermediary did allow salaries for those employees whose W-2s were legible. See, Intermediary's Supplemental Position Paper Exhibit I-6 at page 15.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustments was not included in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 6. Was the Intermediary's adjustment to travel expenses proper?

FACTS:

The Provider claimed travel expenses which the Intermediary disallow due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed some additional travel expenses. See, Intermediary's Supplemental Position Paper at 16.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation available at the facility and, therefore, has no basis to disallow these costs.

The Intermediary states that the Provider submitted additional documentation, and it proposed a revised adjustment to allow additional travel expenses for which invoices and corresponding checks could be traced to the general ledger. See, Intermediary's Supplemental Position Paper Exhibit I-6 at pages 16-20.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not included in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revisions to its adjustment is proper.

Issue 7. Was the Intermediary's adjustment to accounting expense proper?

FACTS:

The Provider claimed accounting expenses which the Intermediary denied due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional documented costs. See, Intermediary's Supplemental Position Paper at 17.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed conduct a review of the documentation available at the facility and, therefore, has no basis to disallow these costs.

The Intermediary notes that the Provider submitted additional documentation in the form of invoices and checks but that much of the documentation was not legible. The Intermediary allowed additional costs for accounting expense for which documentation was legible and could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at pages 24-26.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not included in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 8. Was the Intermediary's adjustment to recruiting costs – Rehab Resources proper?

FACTS:

The costs for recruiting fees were accumulated on the books of the home office cost statement and allocated to the Provider.[5] The Intermediary denied these costs due to lack of supporting documentation and the lack of disclosure of the relatedness of party billing the Provider for these services, Rehab Resources. Exhibit P-8(a) and Exhibit I-10. After reviewing additional documentation supplied by the Provider, the Intermediary continued to deny the costs because the documentation supplied was insufficient. See, Intermediary's Supplemental Position Paper at 17-18.

PARTIES' CONTENTIONS:

The Provider claims that Rehab Resources was not a related party. While acknowledging that its former employees formed Rehab Resources and that it provided Rehab Resources with assistance, the Provider indicates that no stockholder, employee or relative of the Provider had any ownership in Rehab Resources and, therefore, it was not a related party. The Provider acknowledges that it reported Rehab Resources as a related party on an amended cost report that the Intermediary declined to accept. Nevertheless, the Provider continues to maintain that it was not related to Rehab Resources and claims that had the Intermediary reviewed the relationship more closely, it would have come to the same conclusion. The Provider asserts that even if the Board finds that the Provider was related to Rehab Resources, it is still entitled to claim the actual costs of the related organization. However, the Provider states that the Intermediary eliminated all of the costs of the related party without further review. The Provider submitted a list of the actual costs of Rehab Resources that it believes should be allowable even if the Board finds that the parties are related. See, Exhibit P-104 at 12-16.

The Intermediary indicates that the Provider furnished additional documentation to support its claim, but it was insufficient to support the cost of the related organization

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The Provider acknowledged that a key employee, as well as other employees of Rehab Resources, were previous employees of PTK, and that PTK provided Rehab Resources with assistance. See, Provider Position Paper, P8 at 1. Based on this acknowledgement, the Board finds that the parties were related. However, the Intermediary improperly disallowed all costs for Rehab Resources instead of reducing the amount claimed to the costs of the related party. The Board notes that the Provider submitted a list of costs that it believes should be allowable if the Board finds that the parties were related. See, Exhibit P-104 at 12 -16. The Intermediary also refers to other documentation submitted by the Provider to support its claimed costs. See, Intermediary's Supplemental Position Paper at 17. While the Intermediary indicated that the additional information was

[5] See, Intermediary Supplemental Position Paper at 17 and Exhibit I-10.

insufficient, the Board finds that the Intermediary did not review the Provider's recruitment costs for reasonableness, accuracy or their allocation to all providers and other entities served by PTK. The Board remands this matter to the Intermediary to review and allow the actual costs of the related party for which there is adequate documentation to support the costs and their allocation to the Provider.

Issue 9. Was the Intermediary's adjustment to occupational therapy expense proper?

This issue is addressed in Issue 13, below.

Issue 10. Was the Intermediary's adjustment to consultant expense proper?

FACTS:

The Provider claimed consultant expense which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional documented costs. See, Intermediary's Supplemental Position Paper at 18.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

Following the Provider's submission of additional documentation in the form of invoices and corresponding checks, the Intermediary allowed additional costs for consultant expense. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 27-29.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 11. Was the Intermediary's adjustment to maintenance expense proper?

FACTS:

The Provider claimed maintenance expense which the Intermediary disallowed due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional documented costs for maintenance expense. See, Intermediary's Supplemental Position Paper at 19.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices and corresponding checks, the Intermediary allowed additional costs for maintenance expense. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 21-23.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 12. Was the Intermediary's adjustment to contract services – administrative and general - proper?

FACTS:

The Provider claimed the cost of contract services - administrative and general – which the Intermediary denied due to lack of documentation. After review of additional documentation supplied by the Provider, the Intermediary allowed additional costs where documentation could be traced to the general ledger. See, Intermediary's Supplemental Position Paper at 20.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices and corresponding cancelled checks, the Intermediary allowed additional costs that could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 30-32.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 13. Was the Intermediary's adjustment to contract services – occupational therapy expense proper?

FACTS:

The Provider claimed the costs of contract services – occupational therapy which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional documented costs. See, Intermediary's Supplemental Position Paper at 20.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs. The Provider states that the Intermediary relied on CMS Pub. 15-1 §2440 regarding access to books, documents and records of sub-contractors to support its adjustment. The Provider notes that this section only applies to sub-contractors receiving more than $10,000 per year, and this account is below that amount. The Provider also states that the adjustment does not agree with the auditor's workpapers.

After reviewing the Provider's submission of additional documentation in the form of invoices and corresponding checks, the Intermediary allowed additional costs for contract services – occupational therapy expenses that could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 33-35.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 14. Was the Intermediary's adjustment to contract services – physical therapy - proper?

FACTS:

The Provider claimed the costs of contract services - physical therapy which the Intermediary disallowed due to lack of supporting documentation. After reviewing

additional documentation supplied by the Provider, the Intermediary allowed additional documented costs. See, Intermediary's Supplemental Position Paper at 21.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs. The Provider states that the Intermediary relied on CMS Pub. 15-1 §2440 regarding access to books, documents and records of sub-contractors to support its adjustment. However, the Provider notes that this section only applies to sub-contractors receiving more than $10,000 per year, and this account is below that amount.

After reviewing the Provider's submission of additional documentation in the form of invoices and corresponding checks, the Intermediary allowed additional costs that could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 36-37.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issue 15. Was the Intermediary's adjustment to rent expense proper?

FACTS:

The Provider claimed rent expense which the Intermediary disallowed due to lack of documentation. After reviewing additional documentation supplied by the Provider, the Intermediary did not allow any additional rent expense. See, Intermediary's Supplemental Position Paper at 22.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs. The Provider also states that the Intermediary relied on CMS Pub. 15-1 §2440 regarding access to books, documents and records of sub-contractors to support its adjustment. The Provider indicates that the rent was not paid to a sub-contractor. After reviewing the Provider's submission of additional documentation in the form of invoices and corresponding checks, the Intermediary did not allow any additional rent expense because lease agreements were not provided, some checks were for another

location and other checks, were for "PTK Management Rehab Account." See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 38-40.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support its decision not to allow additional rent expense was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's decision not to revise its adjustment was proper.

Issue 16. Was the Intermediary's adjustment to telephone expense proper?

FACTS:

The Provider claimed the costs of telephone expense which the Intermediary disallowed due to lack of supporting documentation. After reviewing additional documentation supplied by the Provider, the Intermediary allowed additional documented costs. See, Intermediary's Supplemental Position Paper at 22.

PARTIES' CONTENTIONS:

The Provider asserts that the Intermediary failed to conduct a review of the documentation that was available at the facility and, therefore, has no basis to disallow these costs.

After reviewing the Provider's submission of additional documentation in the form of invoices and corresponding checks, the Intermediary allowed additional costs for telephone expense that could be traced to the general ledger. See, Intermediary's Supplemental Position Paper, Exhibit I-6 at 41-46.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Although the documentation relied on by the Intermediary to support the revision to its adjustment was not placed in the record by either the Provider or the Intermediary, the Board finds that the Intermediary's proposed revision to its adjustment is proper.

Issues 17 and 18. Were the Intermediary's adjustments to total and other charges – physical therapy proper?

FACTS:

The Intermediary made adjustments to reconcile Medicare therapy charges per the as-filed cost report to the Provider Statistical and Reimbursement Report. Since total therapy charges come from the Provider's records and are not impacted by this reconciliation, decreases in Medicare charges precipitate an increase in "other charges."

Other charges usually represent denied claims for therapy services. After its review of additional documentation furnished by the Provider, the Intermediary did not revise its original adjustment because the Provider did not submit any additional documentation for this issue. See, Intermediary's supplemental Position Paper at 23.

PARTIES' CONTENTIONS:

The Provider disagrees with the Intermediary's increase of the Provider's non-Medicare charges. The Provider claims that non-Medicare charges were not listed on the PS&R and that it maintained financial logs to record all charges. The Provider asserts that these logs were available to the Intermediary during the review but the Intermediary did not make a written request for this information. The Provider contends that the adjustments were made without any basis and should be reversed.

The Intermediary made adjustments to reconcile the Medicare charges and other charges to agree with the PS&R and to reconcile to total charges. The Intermediary offered to review any additional records produced by the Provider.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The Intermediary offered to review the Provider's records to determine whether the adjustments for charges should be reversed. However, there is nothing in the record to indicate that the Provider made those records available to the Intermediary. In addition, the record does not contain the Provider's financial logs. Without any documentation to support the Provider's claim, the Board finds that the Intermediary's adjustments to reconcile the Medicare charges and other charges to agree with the PS&R were proper.

Issue 19. Were the Provider's requests for the inclusion of additional costs for depreciation and reimbursable bad debts for which no adjustments were made proper? (Provider's Issues 19 and 20)

The Provider did not claim the correct depreciation expense in its cost report, and the Intermediary indicated that the depreciation schedule prepared and approved by the Intermediary in previous years would be reviewed and the appropriate depreciation allowed. See, Intermediary's Supplemental Position Paper at 25.

The Provider claimed Medicare bad debts of $7,336 on its as-filed cost report which the Intermediary did not adjusted. However, during its subsequent audit, the Intermediary

found that the Provider erroneously offset "non-allowable" and Medicare bad debts of $19,377 and $7,336, respectively on Worksheet A-3 of its as-filed cost report. This resulted in a reduction in its allowable administrative and general expenses of $26,713. The Intermediary proposes to reverse these negative offsets, thereby increasing the Provider's allowable cost.

PARTIES' CONTENTIONS:

The Intermediary stated that the depreciation schedule prepared and approved by the Intermediary in previous years would be reviewed and the appropriate depreciation allowed.

The parties' contentions regarding the bad debt issue are irreconcilable. The Provider maintains that the intermediary disallowed its claimed Medicare bad debts of $7,336. The Intermediary states that it made no adjustment to bad debts and, therefore, the issue cannot be appealed but must be handled as a reopening. See, Provider Position Paper at P-19 and Intermediary Supplemental Position Paper at 24. Based on the Board's review of the final settled cost report and the related Intermediary adjustments, the only bad debt disallowance was the one made by the Provider itself in its as-filed cost report.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The Intermediary indicated that it would review the previously approved depreciation expense and allow the appropriate depreciation expense, and the Board remands this matter to the Intermediary for that purpose.

The Board also finds that the Intermediary allowed all of the Provider's claimed Medicare bad debts. Finally, the Board finds that the Intermediary proposed reversal of the erroneous bad debt offsets made by the Provider in its as-filed cost report is proper.

Issue 21. Was the Intermediary's adjustment to total expenses proper?

FACTS:

The Intermediary initially disallowed certain administrative costs, but after reviewing additional documentation supplied by the Provider, the Intermediary allowed the administrative costs. See, Intermediary's Supplemental Position Paper, Exhibit I-4 at 1.

PARTIES' CONTENTIONS:

The Provider states that the Intermediary removed the administrative costs because it was unable to reconcile these costs to the cost report. However, the Provider indicates that the Intermediary already disallowed a substantial amount of administrative costs and that

this adjustment duplicates this disallowance.

The Intermediary did not address this issue in its position papers; however, the administrative cost adjustment is reversed in the Intermediary's proposed reopening adjustments. Id.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The Intermediary has proposed reversing the adjustment to total expense for the administrative costs. Id. The Board finds that the Intermediary's proposed adjustment is proper.

DECISIONS AND ORDERS:

Issue 1. Did the Intermediary improperly reopen the cost report?

The Board finds that the Provider's December 31, 1995 as-filed cost report did not become a final determination and that the Intermediary's June 27, 2000 NPR is the Intermediary's final determination.

Issues 2-4. Were the Intermediary's adjustments to salaries – physical, speech and occupational therapy proper?

The Board finds that the Provider submitted additional documentation to the Intermediary to support a revision to the Intermediary's original adjustment and affirms the Intermediary's proposed revision to allow additional physical, speech and occupational therapy costs.

Issue 5. Was the Intermediary's adjustment to salaries - administrative proper?

The Board finds that the Provider submitted W-2 forms as additional documentation of its administrative salaries and that the Intermediary agreed to allow the costs that are supported by legible W-2s. The Intermediary's proposed adjustment allowing additional administrative salaries is affirmed.

Issue 6. Was the Intermediary's adjustment to travel expenses proper?

The Board finds that the Provider submitted additional documentation to support its travel expenses, and the Intermediary proposed a revised adjustment to allow travel expenses that could be substantiated. The Board finds the Intermediary's proposed adjustment to be proper and is affirmed.

Issue 7. Was the Intermediary's adjustment to accounting expense proper?

The Board finds that the Provider submitted additional documentation to support its accounting expense, and the Intermediary allowed additional costs for which documentation was adequate. The Board finds the Intermediary's revision to its adjustment for accounting expense is proper.

Issue 8. Was the Intermediary's adjustment to recruiting cost – Rehab Resources proper?

The Board finds that the Intermediary did not review the Provider's recruitment costs for reasonableness, accuracy or their allocation to all providers and other entities served by PTK. The Board remands this matter to the Intermediary to review and allow the actual costs of the related party for which there is adequate documentation to support the costs and their allocation to the Provider.

Issue 9. Was the Intermediary's adjustment to occupational therapy expense proper?

This issue is addressed in Issue 13, below.

Issue 10. Was the Intermediary's adjustment to consultant expense proper?

The Board finds that the Provider submitted additional documentation to support its consulting expense, and the Intermediary allowed additional costs for which documentation was adequate. The Board finds the Intermediary's revision to its adjustment for consulting expense is proper

Issue 11. Was the Intermediary's adjustment to maintenance expense proper?

The Board finds that the Provider submitted additional documentation to support its maintenance expense, and the Intermediary allowed additional costs for which documentation was adequate. The Board finds the Intermediary's revision to its adjustment for maintenance expense is proper.

Issue 12. Was the Intermediary's adjustment to contract services - Administrative and General proper?

The Board finds that the Provider submitted additional documentation to support its contract services – administrative and general expense, and the Intermediary allowed additional costs for which documentation was adequate. The Board finds the Intermediary's revision to its adjustment for contract services – administrative and general expense is proper.

Issue 13. Was the Intermediary's adjustment to contract services – occupational therapy proper?

The Board finds that the Provider submitted additional documentation to support its contract services – occupational therapy expense, and the Intermediary allowed

additional costs for which documentation was adequate. The Board finds the Intermediary's revision to its adjustment for contract services - occupational expense is proper.

Issue 14. Was the Intermediary's adjustment to contract services – physical therapy proper?

The Board finds that the Provider submitted additional documentation to support its contract services – physical therapy expense, and the Intermediary allowed additional costs for which documentation was adequate. The Board finds the Intermediary's revision to its adjustment for contract services – physical therapy expense is proper.

Issue 15. Was the Intermediary's adjustment to rent expense proper?

The Board finds that the Provider did not provide sufficient documentation to support its rental expense. The Intermediary's adjustment is affirmed.

Issue 16. Was the Intermediary's adjustment to telephone expense proper?

The Board finds that the Provider submitted additional documentation to support its telephone expense, and the Intermediary allowed additional costs for which documentation was adequate. The Board finds the Intermediary's revision to its adjustment for telephone expense is proper.

Issues 17-18. Was the Intermediary's adjustment to total and other charges – physical therapy proper?

The Board finds that the Provider did not furnish documentation to support its claim that the Intermediary's adjustment to total and other charges – physical therapy was incorrect. The Intermediary's adjustment is affirmed.

Issue 19. Were the Provider's requests for additional costs for depreciation and reimbursable bad debts proper? (Provider's Issues 19 and 20)

The Intermediary indicated that it would review the previously approved depreciation schedule and allow the appropriate depreciation expense. The Board remands this matter to the Intermediary to allow the appropriate depreciation expenses.

With respect to Medicare bad debts, the Board finds that the Intermediary initially allowed the Provider's Medicare bad debts and proposed an adjustment to reverse an offset of the Provider's bad debts to agree with the revised trial balance. The Intermediary's proposed adjustment is affirmed.

Issue 21. Was the Intermediary's adjustment to total expenses proper?

The Board finds that the Intermediary proposed reversing the adjustment to total expense for the administrative costs. The Intermediary's proposed adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

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Gary Blodgett, D.D.S.
Elaine Crews Powell, CPA
Anjali Mulchandani-West

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson